

# **SEIZURE ACTION PLAN**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant medical history: \_\_\_\_\_

## **SEIZURE INFORMATION:**

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: \_\_\_\_\_

Student's reaction to seizure: \_\_\_\_\_

**BASIC FIRST AID: CARE & COMFORT:** *(Please describe first aid procedures if different than Basic Seizure First Aid)*

### **Basic Seizure First Aid:**

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

### **For tonic-clonic (grand mal) seizure:**

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

## **EMERGENCY RESPONSE:**

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at \_\_\_\_\_
- ☐ Call 911 for transport to \_\_\_\_\_
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other \_\_\_\_\_

### **A Seizure is generally considered an Emergency when:**

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

## **TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)**

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom: \_\_\_\_\_

**SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:** *(regarding school activities, sports, trips, etc.)*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_